

**Reproductive Health  
Case Study**

**NEPAL**

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**The POLICY Project**

**The Futures Group International**

*in collaboration with*

**Research Triangle Institute (RTI)**

**The Centre for Development and  
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## ***Executive Summary***

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified worldwide focus on reproductive health policies and programs. Many countries have worked to adopt the recommendations from the ICPD *Programme of Action* and to shift their population policies and programs from an emphasis on achieving demographic targets for reduced population growth to a focus on improving the reproductive health of their population. The POLICY Project has conducted eight country case studies to assess each nation's process and progress in moving toward a reproductive health focus. The purpose of the country reports is to describe the policy environment for reproductive health and the role of the 1994 ICPD in sparking and shaping policies and programs in reproductive health.

The field work for the Nepal Reproductive Health Case Study was conducted from August 15 to 27, 1997. Nineteen persons active in the population and health sector were interviewed in accordance with a series of questions designed to elicit information regarding the policy environment and the status of reproductive health activities. All respondents were based in Kathmandu, the capital city, and Kakani, a small town about 45 kilometers from Kathmandu. Respondents included representatives from government organizations, nongovernmental organizations (NGOs), technical assistance organizations, research organizations, donors, the private sector, and service providers.

Nepal has achieved some progress in policymaking for reproductive health. However, the major documents lack consistency, and the chief actors involved in implementing reproductive health services have not forged consensus on the approach to delivering such services. Nepal has set forth a comprehensive reproductive strategy but lacks adequate resources to undertake full-scale implementation and has not yet set priorities. Much remains to be accomplished to overcome the major constraint to health service delivery in Nepal—lack of trained manpower and staff shortages at health facilities. Currently, some reproductive health services are available at separate service delivery sites (and usually on separate days) through the Family Health Division of the Department of Health Services, Ministry of Health. In addition, separate organizational structures are responsible for the provision of different interventions for reproductive health. These separate structures undermine an integrated approach to reproductive health service delivery. Moreover, some donors are implementing projects in selected districts that address subcomponents of reproductive health. In an effort to develop a more efficient public/private partnership for health service delivery, the public sector and NGOs are working jointly toward reducing differences in approaches. Representatives from organizations involved in reproductive health in Nepal are aware of the problems in the current system and are working to ensure that the reproductive health needs of the people of Nepal are met through high-quality, client-oriented services.

## ***Abbreviations***

AIDS	acquired immune deficiency syndrome
CBS	Central Bureau of Statistics
CRS	Contraceptive Retail Sales
DFID	Department for International Development
DoHS	Department of Health Services
EPI	Expanded Program on Immunization
FHD	Family Health Division
FPAN	Family Planning Association of Nepal (IPPF affiliate)
GTZ	German Technical Cooperation
HIV	human immuno-deficiency virus
HMG	His Majesty's Government
ICPD	International Conference on Population and Development
IEC	information, education, and communication
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
KAP	knowledge, attitudes, and practice
KFW	German Development Bank
MCH	maternal and child health
MOH	Ministry of Health
MOPE	Ministry of Population and Environment
NCASC	National Center for AIDS and STD Control
NCP	National Commission on Population
NFCC	National Fertility Care Center
NFHS	National Family Health Survey
NGO	nongovernmental organization
ODA	Overseas Development Agency
RTI	reproductive tract infection
STD	sexually transmitted disease
TBA	traditional birth attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
WHO	World Health Organization

# 1. Introduction

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified worldwide focus on reproductive health policies and programs. Many countries have worked to adopt the recommendations from the ICPD *Programme of Action* and to shift their population policies and programs from an emphasis on achieving demographic targets for reduced population growth to a focus on improving the reproductive health of their population.

The POLICY Project has conducted eight country case studies to assess each nation's process and progress in moving toward a reproductive health focus. Case studies were conducted in Bangladesh, Ghana, India, Jamaica, Jordan, Nepal, Peru, and Senegal. The purpose of the country reports is to describe the policy environment for reproductive health and the role of the 1994 ICPD in sparking and shaping policies and programs in reproductive health. A report summarizing experiences across the eight countries and examining trends in the development and implementation of reproductive health policies and programs accompanies the country reports.

Based on epidemiological significance and recommendations from the ICPD *Programme of Action*, reproductive health care in the case studies is defined as including the following elements:

- prevention of unintended pregnancy through **family planning services**;
- provision of **safe pregnancy services** to improve maternal morbidity and mortality, including services to improve perinatal and neonatal mortality;
- provision of **postabortion care services** and abortion services, where permitted by law;
- prevention and treatment of reproductive tract infections (RTIs) and sexually transmitted diseases (STDs) and **HIV/AIDS**;
- provision of **reproductive health services to adolescents**;
- improvement of **maternal and infant nutrition** including promotion of **breastfeeding programs**;
- screening and management of **specific gynecological problems** such as **reproductive tract cancers**, including **breast cancer**, and **infertility**; and
- addressing of **social problems** such as prevention and management of harmful practices, including **female genital mutilation** and **gender-based violence**.

The country case studies were conducted through in-depth interviews with individuals in the areas of population and reproductive health. Respondents included representatives from government ministries, parliaments, academic institutions, nongovernmental organizations (NGOs), women's groups, the private sector, donor agencies, and health care staff. Not all groups were represented in each country case study. The interview guide included the definition of and priorities for reproductive health; how reproductive health policies have been developed; the committees or structures responsible for reproductive health policy development, including the level of participation from various groups; support for and opposition to reproductive health; the role of the private sector and NGOs; how services are implemented; national and donor funding for reproductive health; and remaining challenges to implementing reproductive health policies and programs. Interviews focused on the sections of the interview guide where the respondent had knowledge and expertise. POLICY staff or consultants served as interviewers for the case studies.

The field work for the Nepal case study was conducted from August 15 to 27, 1997. Nineteen persons active in the population and health sector were interviewed regarding the policy environment and the status of reproductive health activities. All respondents were based in Kathmandu, the capital city, and

Kakani, a small village in the Nuwakot district about 45 kilometers from Kathmandu. Appendix 1 lists the organizational affiliations of respondents.

## 2. Background

With a per capita gross domestic product of \$220 in 1995–1996 (CBS, 1997a), Nepal is among the poorest and least developed countries in the world. About 65 percent of the population lives below the poverty line (CBS, 1997b). Agriculture is the mainstay of the economy, providing a livelihood for over 80 percent of the population and accounting for 60 percent of the gross domestic product. Agricultural production in the late 1980s grew by about 5 percent annually as compared with an annual population growth rate of 2.6 percent (MOA, 1997). More than 40 percent of the population is undernourished, partly because of poor distribution. The top 10 percent of the population receives 47 percent of total income, the bottom 20 percent receives less than 5 percent (CIA, 1993).

The population of Nepal was estimated at 21.1 million in 1996 (CBS, 1995). Occupying a land area of 147,181 square kilometers, Nepal is landlocked between the world's two most populous nations—India and China. Nepal's three geographic zones—the Terai (flat land bordering India), the Hills, and the Mountains—are easily distinguished by population density figures. In 1991, the population density in the Terai belt (254 persons per square kilometer) was more than double the national figure (125 persons per square kilometer). Because of its topography, harsh terrain, limited transportation, and poor communication facilities, the Mountain region is host to only 8 percent of Nepal's population but has a population density of 28 persons per square kilometer. The population density in the Hill area is 137 persons per square kilometer (CBS, 1995).

Nepal's population more than doubled in the last 35 years. Even though the total fertility rate declined only somewhat from a level of 6.3 in 1971 to 5.6 children per woman in 1991, the desired family size has decreased from four children in 1976 to three children in 1991 (MOH, 1993). In 1996, the National Family Health Survey (NFHS) revealed that, on average, women were experiencing 4.6 births during their lifetime (Pradhan et al., 1997). Nepal has made modest progress in its family planning program, increasing the contraceptive prevalence rate for modern methods from 3 percent in 1976 to over 26 percent in 1996. Despite these gains, the nation's unmet need for family planning services was estimated at 31.4 percent in 1996, up from 28 percent in 1991 (Pradhan et al., 1997). While the percentage of total demand satisfied for family planning services over the period 1991–1996 rose from 42 to 46 percent, the increase in levels of unmet need is suggestive of a gap in knowledge, attitudes, and practice (KAP) (MOH and Macro International, 1997).<sup>1</sup> Nepal's family planning program has relied heavily on achieving demographic targets through the provision of sterilization services. Consequently, 85 percent of the demand for spacing methods remains unmet. The unmet need increased noticeably in the Mountain region, probably because of the lack of availability of services in that region relative to other regions. The government of Nepal has set a goal of reaching a fertility rate of 4 by the year 2000, which means that the contraceptive prevalence rate must increase from its current level of 29 percent to 38 percent by 2000 (MOH and Macro International, 1997).

Although many health statistics have shown improvement in recent years, much work remains to be done. Nepal's maternal mortality ratio is among the highest in the world: 1,500 maternal deaths per 100,000 live births, and the life-time risk of maternal death is 1 in 10 (WHO and UNICEF, 1996). The 1996 Family Health Survey, however, reported a maternal mortality ratio of 539 per 100,000 live births (based on the

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<sup>1</sup> The KAP gap is the percentage of currently married women who say they do not want any more children but are not using a method of contraception.



sisterhood method) (Pradhan et al., 1997). The government has set a target of reducing maternal mortality to 400 per 100,000 live births by 2002. Statistics also demonstrate a distinct son preference (Karki, 1988). Table 1 shows some key reproductive health indicators for Nepal.

**Table 1. Selected Reproductive Health Indicators, Nepal 1996**

<b>Indicator:</b>	
Maternal mortality ratio (maternal deaths per 100,000 live births)	539
Births receiving no prenatal visit (percent)	56
Births delivered at home (percent)	92
Births receiving no assistance from trained personnel (percent)	90
Mean time to health facility	
Mountain	86 minutes
Hill	61 minutes
Terai	40 minutes
Cumulative HIV/AIDS cases (July 1997)	790
National STD incidence (per 100 population)	.06
Pregnant women with anemia (percent)	63
Births exclusively breastfed in the first 4–6 months (percent)	52
Infant mortality rate (infant deaths per 1,000 live births)	78

**Source:** Pradhan et al., 1997; MOH and Macro International, 1997

Thirty-nine percent of pregnant women had at least one antenatal care visit, but only 4 percent received a complete antenatal care package consisting of four visits (with the initial visit in the first six months of pregnancy), one dose of tetanus toxoid, and iron and folic acid tablets. Only 10 percent of women deliver their babies with the assistance of a trained health provider (Table 1). The low level of antenatal and other health care services is associated with the phenomenon of silent suffering (Khattab, 1992; Thapa, 1996a). Most rural women are reluctant to avail themselves of services because of shyness, sociocultural barriers, and the perception that pregnancy is a natural state, not an illness, and therefore does not require care unless a significant health problem arises. In the Bajura District of Nepal, traditional beliefs influence childbearing practices. Pregnant women are confined to the cow shed during delivery and are responsible for delivering the newborn and cutting the cord. No one, including friends, relatives, and traditional birth attendants (TBAs), is allowed to assist (Thapa, 1996b). An additional factor in low utilization of services is the lack of female providers (Baker, 1994) and poor access to services (Regmi and Manandhar, 1997). Abortion is illegal in Nepal, although anecdotal evidence suggests that unsafe abortions may significantly contribute to maternal mortality.

Breastfeeding statistics and child mortality rates are useful indicators of the status of child health. Breastfeeding is nearly universal; 95 percent of infants are still breastfed at the end of their first year of life. Nonetheless, supplementation begins at an early age with water and other liquids, such that only 52 percent of four- to six-month-old infants are exclusively breastfed. Although mortality figures are declining, the infant mortality rate remains at 79 per 1,000 live births and the child mortality rate at 43 per 1,000. The mortality rate for children under five years of age is 118 per 1,000, which means that nearly one in eight children born in Nepal dies before reaching the age of five (Pradhan et al., 1997).

With national studies on STDs yet to be conducted in Nepal, no national data about prevalence are available. Although the multiple effects of AIDS have so far been minimal, the potential impact is immense (MOH, 1997a) and could undermine the development efforts of Nepal's socioeconomic and health sectors. The first AIDS case in Nepal was detected in 1988. Since then, AIDS cases have been steadily increasing; as of July 1997, cumulative HIV/AIDS cases had reached 790. Despite relatively the low numbers of identified AIDS cases in Nepal, experts are concerned about the implied impact of HIV/AIDS because of the open border with India, which has the largest number of AIDS cases in the world. In addition, reported figures represent vast underreporting in Nepal. The National Center for AIDS and STD Control (NCASC) in the Ministry of Health (MOH) estimated the number of HIV positive cases in Nepal in 1994 at 6,000 (Dahlburg, 1994).

### **3. Policy Formulation**

#### **A. Structures for Policymaking**

##### **National Level**

In Nepal, the MOH is the government body that is ultimately responsible for policymaking in reproductive health. The MOH embodies a Division of Policy, Planning, Foreign Aid and Monitoring and a Department of Health Services (DoHS). The DoHS has the following divisions: Planning and Foreign Aid, Family Health, Child Health, Epidemiology and Disease Control, Logistics Management, Human Manpower and Institutional Development, and Leprosy Control (see Appendix 2 for the organizational structure of the DoHS). Policymaking, the formulation of annual, five-year, and long-term plans, and donor coordination are the responsibilities of the MOH with relevant inputs from the DoHS (MOH, 1997a).

The MOH was reorganized in 1993-1994 to implement the recommendations of the *National Health Policy* of 1991. At the same time, it merged all its vertical programs into the above divisions. The Family Health Division (FHD) provides public sector family planning services, including reproductive health. The Division of Child Health provides services such as preventive and curative child health care, including the Expanded Program for Immunization (EPI), and the Diarrheal Disease Control and Acute Respiratory Infection programs. Five national centers (see Appendix 2) are lodged in the DoHS. Among them, the NCASC is responsible for developing policies relating to AIDS and STDs.

The National Planning Commission Secretariat formulates national policies and long-term plans for all sectors and monitors the activities of various ministries. The relevant divisions of the MOH develop health policies, guidelines, and strategies for approval by the Director General for Health Services, Secretary of Health, or the Health Minister. Internal guidelines, such as *National Service Delivery Guidelines for Family Planning*, do not always require the approval of the National Planning Commission, but most documents are subject to the approval of that body.

In 1995, a new Ministry of Population and Environment (MOPE) was created, along with four other new ministries. A respondent from an U.S. technical assistance organization commented, "It was not a decision based on need but on stabilizing the political system. Now the MOPE is attempting to establish its role as a ministry responsible for developing population policies and coordinating activities linked to population, reproductive health, and environment." One impediment to expanding the role of the MOPE is that the ministry has status equivalent to that of other ministries, including the MOH. Previously, responsibility for the development of population policies rested with the National Planning Commission

Secretariat. In any event, the MOPE has yet to emerge with a clear mandate relative to the MOH to preclude any overlap of roles and responsibilities.

Finally, the National Population and Development Committee consists of about 30 parliamentarians and is chaired by the prime minister. The purpose of the committee is to address issues relating to population and development and to highlight these issues in the parliamentary system. According to the respondents, the committee has not met in the last few years.

## NGOs

The level of participation among various private sector groups in reproductive health policymaking is generally low, although the MOH, and to some extent reproductive health NGOs, participate in policy forums. In 1995, international and local service delivery NGOs established an NGO Coordinating Council.

Respondents largely agreed, however, that NGOs and the government have not yet engaged in fruitful collaboration. Council representatives mentioned that they invite MOH officials to their meetings, but, according to one respondent, “No one shows up.”

“NGOs are not really involved in development of plans. Government does not truly consider the NGOs their partner. Such talk is jargon.”  
NGO representative

Most MOH officials reported that NGOs were asked to participate in key strategic discussions, particularly after the ICPD. Nevertheless, officials gave the impression that the government was not clear about the role of NGOs and noted that the NGO Coordination Unit within the MOH was not functioning. One MOH representative commented, “NGOs are playing a bigger role [than the role NGOs had played earlier] in advocacy and IEC [information, education, and communication] for issues of women’s empowerment, AIDS/STDs, and adolescent programs.”

An MOH representative stated, “The NGOs try to replicate services where the MOH is already providing services. They should seek out areas where it is not feasible for the government to reach.” Several respondents mentioned that the government/NGO partnership is not working because of political instability, NGOs’ ability to offer higher salaries than those paid by government, and the tendency of some politicians to align themselves with certain NGOs.

## Private Sector

Nepal’s eighth and ninth five-year plans support an expanded role for both NGOs and the private sector. Most respondents saw no barriers to private sector development, especially given that the government has

“There are no real barriers to private sector participation, but there is no umbrella organization of the private sector through which dialogue can be initiated.”  
Donor representative

adopted economic liberalization policies. A private sector respondent mentioned, “We cannot tell if the government is pro private sector; there are instances when government policies interfere with private sector expansion. For instance, there is leakage of free public sector commodities into the private sector. This has a major impact on our program.” Although the public sector continues to be an

important source of contraceptives in Nepal, its share of the market has declined in the last five years from 93 percent of current users in 1991 to 79 percent of current users in 1996 (Pradhan et al., 1997). In contrast, the private sector has become increasingly important as a source of medical supplies. For instance, 60 percent of Nepali women cited a private pharmacy as their source for “Jeevan Jal,” a well-recognized commercial brand of the oral rehydration solution frequently used by women to treat diarrhea

in children (Pradhan et al., 1997). Contraceptive Retail Services (CRS), the social marketing company in Nepal, is incorporating safe delivery kits and oral rehydration salts into its product line.

## **Local Level**

Participation in the policymaking process has not yet filtered down to local levels. While Village Development Committees (VDCs) have access to local resources, they are not engaged in policy dialogue for reproductive health. One MOH representative mentioned, “Community participation is key to success; just as some schools are being run by communities, so should health centers.”

## **B. Evolution of Policies from Family Planning to Reproductive Health**

Nepal’s first (1955–1960) and second development plans (1960–1965) included no specific population policies. The third development plan (1965–1970) paid greater attention to population dynamics and discussed the consequences of rapid population growth. In fact, poverty alleviation—particularly ameliorating the effects of rapid population growth on development—has been the major focus of Nepal’s development plans since 1965 (UNFPA, 1989). The fourth development plan (1970–1975) set forth clearer objectives on population policy and highlighted the need for a national institution to implement the national family planning program. In 1968, Nepal established the Family Planning and Maternal and Child Health Project.

In 1983, the National Commission on Population (NCP), which was formed in 1979, outlined the *National Population Strategy*. The goal of the strategy was to reduce the fertility rate to 2.5 by 2000. Even though the strategy and subsequent plans stressed the need for lowering fertility, one observer said, “There is no political will in terms of allocating national resources.” In addition, the NCP sought legislation on the legal provision of sterilization and the legalization of abortion under specified conditions. The commission also advocated for amendments increasing the legal age at marriage for women from 16 to 20 years and changing the inheritance laws for unmarried women (UNFPA, 1989). A respondent from the MOPE said that the amendments changing the inheritance laws for women are still pending parliamentary approval and that no decision has been taken on raising the legal age at marriage for women.

Nepal is a signatory to the ICPD *Programme of Action*, and the initial endorsement for undertaking a reproductive health approach originated externally to the MOH. According to an MOH respondent, “The MOH Nepal towed the line of the HMG [His Majesty’s Government], and now has laid down the detailed reproductive health strategy.”

Nepal has formulated several policies that address individual elements of reproductive health. The main objective of the *National Health Policy*, which was adopted in 1991, was to expand preventive and curative health services targeted to the rural population. The policy reorganized the health service, abolished vertical programs, and adopted a more integrated approach to service delivery. In addition, the MOH has adopted several new post-ICPD policies, including those on family planning (*Family Planning Service Related National Policy*), safe motherhood, and STDs and HIV/AIDS (*AIDS and STDs Control Related National Policy*). While Nepal’s health and family planning programs have long embodied many reproductive health elements, the ICPD was significant in inducing policymakers to think in terms of a more comprehensive reproductive approach rather than in terms of individual elements of reproductive health.

Despite the efforts of Nepal’s policymakers, the MOH’s most recently developed health plans and policies—the *Second Long-Term Health Plan (1997–2017)* and the *National Reproductive Health Strategy*—fail to exhibit a unified vision for the provision of health services for Nepal. The *Second Long-*

*Term Health Plan (1997–2017)*, formulated by the Policy, Planning, Foreign Aid, and Monitoring Division of the MOH, envisions a health system that provides “equitable access to coordinated quality health care services in rural and urban areas, characterized by self-reliance, full community participation, decentralization, gender sensitivity, and effective and efficient management resulting in improved health status of the population” (p. 9). It also proposes to give priority to health promotion and prevention activities and the development and implementation of a Basic Health Care Package. Unfortunately, the plan does not specify reproductive health interventions per se.

In August 1997, the MOH and MOPE were working on inputs to the ninth five-year plan (1995–2000). Regrettably, the various policy components remain somewhat disjointed. The MOPE did, however, draft a document entitled *Ministry of Population and Environment (Scope of Work)* that mentions reproductive health as a component of its population activities.

Even so, the detailed descriptions of the primary functions of the ministry do not reflect any specific reproductive health activities except in terms of analysis of fertility and infant and child mortality.

Listed within the supportive functions of the ministry are activities to make better use of data relating to family planning. In addition, the MOPE seeks to implement programs that will help reduce the fertility rate by delaying marriage; expanding female literacy programs; changing social attitudes toward son preference; reducing infant, child and maternal mortality through delayed first birth; offering pre- and postnatal nutrition services; and providing contraception for birth spacing.

“I thought we had drafted a chapter on reproductive health for the *Second Long-Term Health Plan*; I am surprised that it does not appear in the final document.”  
MOH representative

On a more encouraging note, some efforts are currently underway to refocus some of the “pre-Cairo” projects and programs on reproductive health. Respondents noted an increasing number of people affiliated with the public, private, and NGO sectors are talking about reproductive health. As resources become available, various NGOs are adding reproductive health elements. The MOH has discussed the need to rank reproductive health services according to the magnitude of the problem, the capacity of the health system, and resource availability. The development of operational guidelines based on critical information illustrates that Nepal is serious about moving toward a feasible reproductive health approach. However, more than one-half of respondents expressed concern about the slow pace of change and the barriers in the health system that may prevent effective implementation of policies.

### **C. Definition of Reproductive Health**

Nepal has officially adopted the ICPD definition of reproductive health;<sup>2</sup> however, the MOH has made no effort to disseminate the concept to other stakeholders and health care providers.

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<sup>2</sup> 7.2. “Reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.”

“There are 15 different definitions of reproductive health.”

Donor representative

In general, respondents observed little consensus among the various stakeholders on the definition of reproductive health in general and its application to the population of Nepal in particular. A respondent from a U.S. technical assistance organization remarked, “There is no real consensus around the definition of reproductive health; the WHO [World Health Organization] definition of reproductive health is different from what UNFPA

[United Nations Population Fund] supports.” Another MOH respondent complained, “We have a big problem with new concepts. New names are brought in. For example, we first used the term venereal disease, then sexually transmitted diseases, followed by sexually transmitted infections, and now reproductive tract infections. It is the same thing with reproductive health. First it was known as MCH [maternal and child health] then family health and now reproductive health. Half the money just goes in disseminating the new concepts and counseling health workers.” A donor representative commented, “No doctor in the district could define reproductive health.”

An MOH respondent underscored the importance of developing clear guidelines. “The reproductive health policy has been conceptualized and intellectualized but no guidelines have been developed regarding how to approach services.” Given the capacity of the health system and available resources, the MOH plans to reevaluate the set of interventions recommended in the *National Reproductive Health Strategy* and, in fall 1998, embark on a process to set priorities.

The goal of the *National Reproductive Health Strategy* (formally adopted in December 1997) is to make integrated reproductive health services available to all the people of Nepal. The elements of the strategy are considered equally important and include

- family planning;
- safe motherhood, including newborn care;
- child health;
- prevention and management of complications of abortion;
- RTI/STD/HIV/AIDS;
- prevention and management of infertility;
- adolescent reproductive health; and
- problems of elderly women, particularly cancer treatment at the tertiary level/private sector.

The goal of the Basic Health Care Package, as stipulated in the *Second Long-Term Health Plan (1997–2017)*, is to provide the total population with public health measures and essential clinical services. The target is to make the package available by 2001 to 70 percent of the population within 30 minutes travel of their home. The package includes interventions such as safe motherhood and family planning; EPI and hepatitis B vaccine; condom promotion and distribution; a leprosy control program; a tuberculosis control program; and integrated management of the sick child (MOH, 1997a). Within Nepal, the elements of the ICPD *Programme of Action* concerned with reproductive rights and women’s rights have found less acceptance than those associated with health. A donor respondent said, “Reproductive rights, gender equality are just fancy words for Nepal.” At the same time, the *National Reproductive Health Strategy* does not address elements such as reproductive rights and gender-based violence. Furthermore, there has been little or no effort on the part of the MOH to involve other ministries, such as the Ministry of Youth and Sport, Ministry of Women and Child Welfare, and Ministry of Education, in dialogue and activities on reproductive approach.

The level of knowledge about reproductive health varies widely among different groups in Nepal. Knowledge of family planning is universal; however, some groups have little knowledge of reproductive

health and the risks of pregnancy. According to respondents, despite many workshops and seminars that have been conducted by the MOH, NGOs, donors, and policymakers are generally aware of reproductive health but may not understand all the elements. Some respondents mentioned that some policymakers and program managers think of reproductive health as merely new terminology for family planning. In general, the public is knowledgeable about family planning but needs to be educated about other elements of reproductive health. The service providers at a health center mentioned that they had received neither notification of any change in program strategy nor training in reproductive health.

## **D. Support and Opposition**

### **Support for Reproductive Health**

Support for reproductive health among policymakers is generally considered low. Many respondents felt that the current leadership is not highly committed to family planning and reproductive health programs partly because of the frequent changes in leadership in the last four

“The reproductive health policy is partly donor-driven; there is no opposition to the concept but the government policy is not strong enough to enforce the strategy.”

MOH representative

years. As a result, there has not been much effort to gain the support of policymakers. Many respondents mentioned that political instability deters parliamentarians from dealing with new issues. A representative from a U.S. technical assistance organization said, “There is lip service for reproductive health. At the political level there is no seriousness for this topic.”

### **Opposition to Reproductive Health**

Many respondents cited no opposition to reproductive health; however, others named individual organizations that oppose certain elements of reproductive health. As a rule, the groups that do not support reproductive health are small, fragmented, and lack support and influence. Parliament has discussed a bill to decriminalize abortion, but has yet to pass a resolution. Even respondents themselves evidenced some lack of support for the reproductive health strategy. One donor representative said, “The reproductive health Mafia—it does not allow anyone to criticize reproductive health. It does not allow any dissent.” An NGO representative stated, “Reproductive health can dilute family planning programs unless you build incrementally on what is there.”

As previously mentioned, many respondents stated that policymakers are ambivalent about reproductive health. Respondents felt that more concerted efforts were needed to raise awareness and build consensus around reproductive health, especially in relation to safe pregnancy, adolescent health, HIV/AIDS, and abortion. An MOH official said, “There is awareness for HIV/AIDS; however, with a frequently changing government, we need to keep reeducating them.”

## **4. Policy Implementation**

### **A. Operational Policies and Plans**

The *Second Long-Term Health Plan (1997–2017)* is the guiding document for moving toward the adoption of a Basic Health Care Package. In addition, the *National Reproductive Health Strategy* was finalized in 1997. However, the

“Translating policies into action is a big problem for Nepal.”

NGO representative

development of clear operational guidelines for implementing either plan has yet to occur. A representative from a U.S. technical assistance organization remarked, “All components of reproductive health are in place but it does not function. Reproductive health cannot be a reality for Nepal at least below the district level. The FHD needs to determine which set of interventions it can realistically provide and highlight those that it cannot. They have to understand the difference between what is desirable and what is feasible.” An MOH official stated, “Although the reproductive health package is outlined, there has been no decision to implement because of lack of willingness and lack of resources.” Another MOH respondent mentioned that operational plans have not been developed because of the unstable political situation and because the MOH needs additional guidelines on what is feasible to implement. Another NGO representative said, “It is not the lack of policies or laws—it is the enforcement that is a problem.”

The UNFPA has developed its fourth country program focusing on reproductive health. The program endorses many elements of the reproductive health approach. According to respondents, the WHO-sponsored reproductive health strategy workshop that resulted in the 1997 *National Reproductive Health Strategy* follows a different approach, and some experts believe that the strategy is too ambitious for Nepal. A donor representative said, “As a rubric, reproductive health is dangerous. In countries that have strong family planning and AIDS programs, they can organize other reproductive health elements. In Nepal it can further muddy waters.”

“Reproductive health is a supermarket approach—Nepal cannot afford it, at least not below the district level.”

U.S. technical assistance  
organization representative

## **B. Service Delivery Structure**

The MOH is responsible for the delivery of public sector services to Nepal’s five development regions, 14 zones, 75 districts, 3,995 VDCs, and 36 municipalities. The ministry’s DoHS provides preventive and some curative services. According to the institutional framework of the DoHS, the first contact point for basic health services is the subhealth post. Each VDC should have a subhealth post staffed by an auxiliary health worker, an MCH worker, and a village health worker (Regmi and Manandhar, 1997). As a practical matter, the subhealth post serves as a referral center for volunteer cadres of TBAs and Female Community Health Volunteers as well as for community-based activities such as primary health care, EPI outreach, and home visiting (DoHS, 1997). Each subsequent level serves as the referral point in the hierarchy that progresses from subhealth post to health post (headed by a health assistant), to a primary health care center (headed by a medical doctor), to the district hospital, to the zonal hospital, and, finally to the special tertiary care centers in Kathmandu. All hospitals (district, regional, and zonal) fall directly under the Director General of Health Services (who is also the head of the DoHS) but are not represented by a separate central institutional organization. Dispensaries and clinics also provide traditional medical services through the Ayurvedic, Unani, and homeopathic systems.

Although the public sector is the main source of health care for the population, the private and NGO sectors have grown rapidly in recent years and now account for nine private hospitals, 74 private nursing homes, 2,000 private clinics, and over 8,000 pharmacies operating in Nepal (MOH, 1997a; MOH and ODA, 1995). Among the 18,000 registered NGOs, over 250 are active in providing health care (MOH, 1997a). The range of services offered by NGOs extends to tuberculosis treatment, leprosy care, family planning, immunization, eye care, health education, awareness raising, and advocacy.



“The organization responsible for formulating policies and implementing reproductive health programs should be at the level of the Director General of Health Services.”

U.S. technical assistance  
organization representative

The FHD of the MOH is designated as the division responsible for implementing the *National Reproductive Health Strategy*. Currently, the services provided by the FHD include family planning, safe motherhood programs, and primary health care outreach programs. In addition, the FHD manages the TBA and female community health volunteer programs and coordinates, plans, monitors, and evaluates Nepal’s reproductive health

services. However, an anachronism limits the FHD’s policy formulation and implementation capacity—the Child Health Division and the NCASC are at par with the FHD and are responsible for their own activities.

Under the 1991 *National Health Policy*, one subhealth post is sanctioned for a population of 4,000, one health post for a population of 29,000, and one primary health care center for a population of 100,000. As a practical matter, however, 30 to 50 percent of the health posts and subhealth posts have no health staff. A donor representative emphasized the problem: “There are new institutions in the districts but staff is just not there.”

### **C. Integration**

Theoretically, family planning services in Nepal are integrated within the existing health institutions, although family planning, antenatal, postnatal, and immunization services are provided on separate designated days (Pradhan et al., 1997). In most instances, STD services are provided through separate clinics.

Many respondents mentioned that the operational structure within the MOH poses a problem for integrated service delivery. With the FHD as the focal point for reproductive health service delivery in Nepal, it is assumed to be responsible for safe motherhood, child health, and STD/AIDS services. In fact, these activities are the responsibility of other divisions and centers within the DoHS. As an example, an MOH representative stated, “Drugs to treat STDs are not in the essential drug list; therefore, we cannot link up STD treatment even within the health posts where we have trained providers to insert IUDs.” A respondent from a technical assistance organization remarked, “Donors thought that integration at the lower level and compartmentalization at the higher levels could work; [but] the health system should be integrated at the highest level to work [effectively].”

Respondents stressed that there were few efforts to integrate or coordinate reproductive health-related activities with the activities of other ministries. A donor representative mentioned a few ongoing efforts, such as revising curricula for the Population Education Project through MOPE and introducing the concept of reproductive health and young adults programs through the various universities. Nonetheless, most respondents agreed that there was a general lack of outreach to other sectors.

### **D. Ongoing Initiatives**

The Department for International Development (DFID) is supporting a Safe Motherhood Project in 10 districts of Nepal. In addition, now that UNFPA has reduced its support for contraceptive commodities, DFID will provide (along with UNFPA) Depo-Provera injectables. The German Technical Cooperation (GTZ) will also launch a project to improve maternal health in 10 additional districts. The UNFPA’s

fourth country plan focuses on reproductive health and will be devoted to highlighting the gaps in the norms and guidelines for reproductive health and training for providers.

Nepal has been advocating decentralization of health services for nearly three decades; however, attempts at implementation and community participation have been largely ineffective (MOH, 1997a). Recently, with UNFPA support, the MOH identified some pilot districts for “bottom-up planning.”

The Family Planning Association of Nepal (FPAN) has a few projects that address the needs of young adults, including a project that provides vocational skills and training in reproductive health to young girls and a program that focuses on sexuality issues among youth. FPAN is designing some of its programs to work through local volunteers.

The CRS company, which is responsible for the social marketing of reproductive health commodities, recently started an FM radio hotline to respond to questions by Nepali youth. In addition, the National Health Education, Information, and Communication Center operates an FM radio hotline targeting the adolescent population in Kathmandu.<sup>3</sup>

## **E. Constraints**

Nepal has made progress in addressing the reproductive health agenda at the policy level; however, many constraints impede full policy implementation. This section examines some of the existing constraints that may need to be addressed before Nepal can fully adopt the reproductive health approach.

### **Human Resources Development**

In Nepal, partly because of its topology, access to health services remains a major constraint (Pradhan et al., 1997). The 1991 *National Health Policy* laid out an ambitious plan to provide outreach services through the subhealth posts. According to the 1996–1997 annual report of the DoHS services, DoHS met over 80 percent of its target; however, most of the existing health facilities lack basic amenities, such as a water supply and latrines. Furthermore, shortage of personnel continues to be a major barrier to access. An MOH official commented, “The manpower situation is very poor in Nepal. Although we now have a good system of health infrastructure, a big percentage of these facilities are unstaffed.” Another respondent from the MOH remarked, “We need to have community schemes for managing local health posts and staff. Staff should be recruited from the same area.” A representative from an NGO reflected, “We need to provide a better incentive structure for staff to stay. There are security problems for young female health workers in some areas.”

One of the most frequently mentioned constraints concerns Nepal’s human resource situation. An NGO respondent mentioned, “Staff does not stay in place; the government trains the doctors [and nurses] but cannot attract them to stay at post. The government provides no incentives, such as accommodation. The health centers are not well equipped. Some doctors pay a capitation fee to become doctors [and need to recover money]. There is a lack of vision for the country.” The following subcategories of health staff have shown the largest deficit over time: MCH workers, village health workers, auxiliary nurse midwives, physicians, and specialists (MOH and ODA, 1995). The DoHS’s 1996–1997 annual report mentions human resource management issues relating to staff shortages, lack of trained staff, transfers,

“Almost 30 to 50 percent of health facilities lack trained health personnel.”  
Donor representative

<sup>3</sup> The FM hotline was initiated after the field work for this study was completed.

and supervision as the primary concerns among all donors and international NGOs (DoHS, 1997). A report on health service utilization in three districts (Tanahu, Surkhet, and Dhanusha) exemplifies some of the problems mentioned by the respondents. That study found that poor utilization of services was attributable to the location of the health posts, a lack of essential drugs, the attitude of health workers, and the lack of outreach and home visits by village health workers (Karki et al., 1994).

Another critical problem identified by many respondents relates to worker overload. Respondents felt that the addition of new responsibilities for workers could further reduce the number of contacts a health worker would be able to make. One MOH official stated that the reproductive health approach created the need for further refresher training. He commented, “Workers who were trained five years ago need to undergo refresher training. We need to change their mindset because a lot has happened since then.”

Regardless of service level, few MOH staff have an integrated view of reproductive health or even adequate knowledge of population issues. Service providers are not well trained in the concept of reproductive health. One service provider mentioned that he was not aware of the term reproductive health. He had received some training in management of STDs five years ago. Another service provider mentioned the lack of clear guidelines as a constraint to providing effective antenatal care. “We do not know what to check for and what do when a problem arises. Whatever guidelines are revised, they should be disseminated.” Several respondents voiced concern about the training needs that the new reproductive health approach would impose upon the system already burdened by lack of personnel at health facilities.

## **Institutional**

In addition to the problems associated with the MOH’s organizational structure and human resource situation, other constraints relate to the current instability of the political system and the frequent changes in leadership. Since 1994, Nepal has had five prime ministers. With every new government, staff changes cascade down to the level of division chiefs and lower. Many respondents expressed concern about the changes in senior staff on the basis of party lines, a phenomenon frequently referred to as “politicization of the bureaucracy.” One NGO respondent said, “Efficiency of services is very low. This is partly because of lack of leadership and lack of political continuity.” He went on to state, “The political turnaround is too rapid to make any gains in the program.”

A few respondents mentioned corruption as a problem. It is both common and legally permissible for physicians to work in the public sector during the morning and then return to their private practices in the afternoon. Although public sector services are supposed to be provided free,<sup>4</sup> some public sector physicians charge fees at current private sector rates. A private sector representative shared another concern. “Public sector commodities, such as injectables that are provided by the donors to the public sector, often end up being sold in the pharmacies. This leakage provides competition for the commercial or social marketing brands of the same product.”

The quality of care in Nepal’s health services is a barrier to satisfying client needs (MOH, 1997a). With donor support, the FHD established a quality-of-care program for family planning services, including a quality-of-care center. Nevertheless, respondents frequently mentioned inefficient delivery of services and inadequate attention to the quality of care in public sector programs. An NGO respondent stated, “There is no accountability within the government system. There are no monitoring systems.” Another donor respondent reiterated, “We have to improve quality and quantity of public sector services by better management.” The *Second Long-Term Health Plan (1997–2017)* highlights the need for developing effective quality assurance systems from an economic as well as health perspective. It points out that improved efficiency in the delivery of services is essential to realizing savings in the health sector.

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<sup>4</sup> With the exception of a registration fee of 1 to 3 rupees in some places.

Researchers have identified several barriers to effective family planning programs in Nepal. Some relate to the program's high dependence on limiting methods such as sterilization and to incorrect or inadequate information provision to clients and social discrimination in providing services to lower-class clients (Schuler et al., 1985).

## **Role of Donors**

Donors in Nepal have played the major role in influencing the development of reproductive health policy and providing essential funding for program implementation, especially in the public and NGO sectors. Among the several donor-driven projects are programs in safe motherhood, reproductive tract cancers, and HIV/AIDS. Several respondents mentioned that donors have their own area of emphasis within reproductive health. More than one-half of respondents stressed the need to set priorities within the reproductive health strategy and develop a plan for the phased implementation of activities. In resource-poor settings, the strength of donor organizations lies in their funding capacity. Many respondents stated,

"Donors are pressing the government to accept their reproductive health approach. Donor coordination is very weak and there is no consensus on reproductive health among the donors."

NGO representative

however, that the government needs to channel donor resources according to its own priorities and needs. A donor representative stated, "The MOH cannot decide which model is important. MOH should say 'forget it' to the donors, and the donors will still come back."

## **Legal and Regulatory Barriers**

Some legal and regulatory issues persist in Nepal. As mentioned earlier, one such issue relates to the fact that abortion is a criminal offence (under any circumstances) for both the provider and the woman who receives services. In addition, the MOH has been reluctant to incorporate services for unmarried adolescents because the issue is deemed sensitive. One MOH official remarked, "Maybe adolescent reproductive health services are best left to the NGO community."

# **5. Resource Allocation**

## **A. Funding Levels for Reproductive Health**

According to an Asian Development Bank assessment, the per capita expenditure on health in fiscal year 1994–1995 was US\$11, of which the public sector expenditure represented 10.6 percent. Private households made the major contribution to health expenditures at over 74 percent (ADB, 1994). During the past few years, funding levels for health have been increasing in real terms, indicating a higher government commitment to the health program. Respondents agreed unanimously, however, that the program is overly dependent on donor funds. Nepal's eighth five-year plan expected 65 percent of program costs to be financed through foreign aid contributions (MOH, 1997a). Indeed, the role of foreign aid in support of the development budget for the health sector has increased from 35.9 percent in 1991–1992 to 48.5 percent in 1994–1995. Basic health care, including primary health care activities (as compared to tertiary health care), received an even higher proportion of external assistance, over 56 percent in 1994–1995 (MOF, 1996).

**Table 2: Trends in Resource Allocation for Health**

	1991– 1992	1992– 1993	1993– 1994	1994– 1995	1995– 1996	1996– 1997
Total expenditure (Current price–Rs. in millions)	918.1	1,061.0	1,065.6	1,495.6	2,178.7	3,457.9
Total expenditure (Real–Rs. in millions)	918.1	961.0	898.0	1,182.6	1,595.2	2,418.8
Health as percent of total expenditure	3.47	3.43	3.17	3.82	4.67	5.99
Health as percent of gross domestic product	0.63	0.64	0.55	0.71	0.90	1.26

**Source:** Ministry of Finance, 1996

It became evident during the course of the interviews that information on resource allocation was of concern to most respondents. Interestingly, responses to questions on the level of funding available for reproductive health showed wide variation. Some experts mentioned that overall funding was increasing but was insufficient to meet the demand for reproductive services. One donor respondent mentioned, however, “Funding had not increased and donors were the main defaulters. This means that donors are not coming forth with resources they committed to at ICPD.” An MOH official noted, “Although the donors are putting in more resources, the MOH does not like the idea of providing a different subset of services in different regions.” Until 1997, the budget did not include a line item for reproductive health. According to an MOH respondent, budget reporting had recently changed from family planning and MCH to family planning and reproductive health.

## **B. Major Donors**

Respondents listed the UNFPA, United Nations Children’s Fund (UNICEF), USAID, WHO, the World Bank, the German Development Bank (KFW), GTZ, and the DFID as the major donors in reproductive health. UNFPA’s main focus for the fourth country program is reproductive

“The regional approach of donors is not the preference for the MOH.”  
MOH representative

health; other donors are funding subcomponents of reproductive health. One donor respondent commented, “The government is shy to approach donors. They only work with donors they are used to working with. The donors should get together and fund one plan of action.” An NGO official commented, “Money is available but the government has used only 9 percent of the World Bank loan since 1994.” An MOH representative voiced concern about Nepal losing funds to other countries because of the current political instability. “UNFPA funding has gone up. However, the reproductive health model was going to be funded by WHO in Nepal. That money has gone to Thailand now. Funding is linked to personalities in position and the trust the donors have in them.” Several government officials, NGO representatives, and individuals from the donor community mentioned that donor coordination was weak. An NGO representative said, “There needs to be more sharing of information among donors. Another MOH respondent remarked, “Donors are doing different activities in the name of reproductive health.”

## **C. Financial Sustainability**

Most interviewees acknowledged that financial sustainability of the overall public health program is emerging as an issue. The government’s recent five-year development plans mentioned the need to

expand the role of the private and NGO sectors in service delivery (National Planning Commission Secretariat, 1992). In general, government policy on the public/private mix in the financing and provision of health services has focused on three principal areas: privatization; use of community financing schemes, particularly with respect to essential drugs; and income generation at public facilities (MOH, 1997a).

Cost-sharing schemes in some health centers require all attending patients to pay a token registration fee and per item charges for essential drugs. A joint government and WHO community drug supply scheme recovers partial costs for essential drugs through token fees and subsidized costs. A donor commented, "Community drug schemes are a problem. There are instances of corruption and in many places there are no banks to safeguard the money." A service provider responsible for implementing the community drug scheme noted, "We had problems convincing clients to pay money initially. We charge them 10 percent below retail. However, we were able to motivate people by ensuring that drug supplies never ran out." Even service providers felt that operating a community drug scheme contributed to additional work for the medical staff, some respondents said that such a program offers several advantages, namely greater flexibility in the type of drugs supplied, more attention devoted to expiry dates, and 24-hour availability of the drug. With donors pushing and almost entirely funding the reproductive health agenda, the sustainability of Nepal's reproductive health program remains highly questionable.

## 6. Challenges

Respondents agreed that progress in reproductive health has been slow in Nepal, but they were divided in their views on the current situation and the outlook for the future. Some respondents were skeptical about the current move toward a reproductive health approach in Nepal. They agreed with the concept of reproductive health but were concerned about its applicability. One respondent said, "Reproductive health was introduced too soon in Nepal. Nepal is not ready for this approach." Other respondents expressed optimism, saying that Nepal was moving in the right direction. Despite their diversity of opinion, respondents agreed that Nepal needs to address a number of challenges in the coming years.

- **Improving coordination.** Reproductive health is complex and with respect to implementation, involves a large number of stakeholders, including numerous ministries, donors, and NGOs. Coordination of all these groups is a daunting task. Respondents expressed a need for more information sharing, improved donor coordination, and a higher level of participation in decision making among NGOs, the private sector, and other stakeholders.
- **Ensuring program survival amid political uncertainty.** Respondents stressed that political instability in Nepal has slowed all programs. For the ensured success of programs, greater effort should be devoted to building political commitment and developing management capability at different levels. Respondents also stressed the importance of working with communities and building community ownership of health programs.
- **Solving resource issues (human and financial).** Manpower constraints and more effective use of financial resources represent major challenges for Nepal, not just for implementing reproductive health programs but also for implementing all health programs. One NGO respondent said, "We need to improve the quantity and quality of health programs by better management." Most respondents reiterated that reproductive health programs could be successful only if the above resource issues are resolved.

- **Building true partnerships.** Most respondents noted that NGOs and the private sector are unclear as to their respective roles in providing reproductive health services. They expressed a need for developing a strategic framework that would guarantee an effective public/private mix of services.
- **Building incrementally on existing programs.** The *National Reproductive Health Strategy* outlined a comprehensive approach to providing reproductive health services. Many respondents felt, however, that the strategy may have been too ambitious for Nepal given the country's financial and human resource constraints. A donor representative said, "We need to deal with basic needs first. We can identify a few reproductive health priorities and among the existing programs, identify the ones that should become more important." The government did not move on the strategy until recently.<sup>5</sup> Respondents stressed the need to establish priorities and to identify key interventions that are feasible in terms of implementation while ensuring the greatest impact within the available resources.
- **Moving from planning to action.** Since the ICPD, NGOs and donors have held many seminars to build support for the ICPD *Programme of Action*. Thus far, however, the government has not taken any steps to implement the *National Reproductive Health Strategy*, and only a few donor-supported pilot projects in reproductive health are underway in the field.

Respondents were unanimous in their belief that it is too soon to evaluate the impact of Nepal's new reproductive health focus, pointing out that only three years have passed since the ICPD. An NGO respondent said, "Adopting a new approach can be a slow process, but in Nepal the pace has been frustratingly slow." Some others argued that the ICPD provided a framework but no operational guidelines. One respondent said, "The Cairo document was created in a vacuum—it is a perfect document for an ideal situation. It did nothing to alert you to reality." Most respondents felt that Cairo has helped programs become more women-centered and focused on client needs and that it has created an awareness of the need to improve NGO participation and build community ownership.

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<sup>5</sup> After the completion of the interviews, the government (with UNFPA support) has, with the adoption of the *National Reproductive Health Strategy*, set up two new coordinating groups. The first is a policy-level, intersectoral steering committee (chaired by the Secretary of Health) and composed of secretary-level representatives from ministries and organizations, such as the Ministry of Law and Justice, Ministry of Women and Social Welfare, Ministry of Local Development, MOPE, Ministry of Education, National Planning Commission, and donors. The second is an operational-level coordinating committee chaired by the Director of the FHD that includes directors within the MOH and representatives from NGOs, international NGOs, and donors.

## ***Appendix 1***

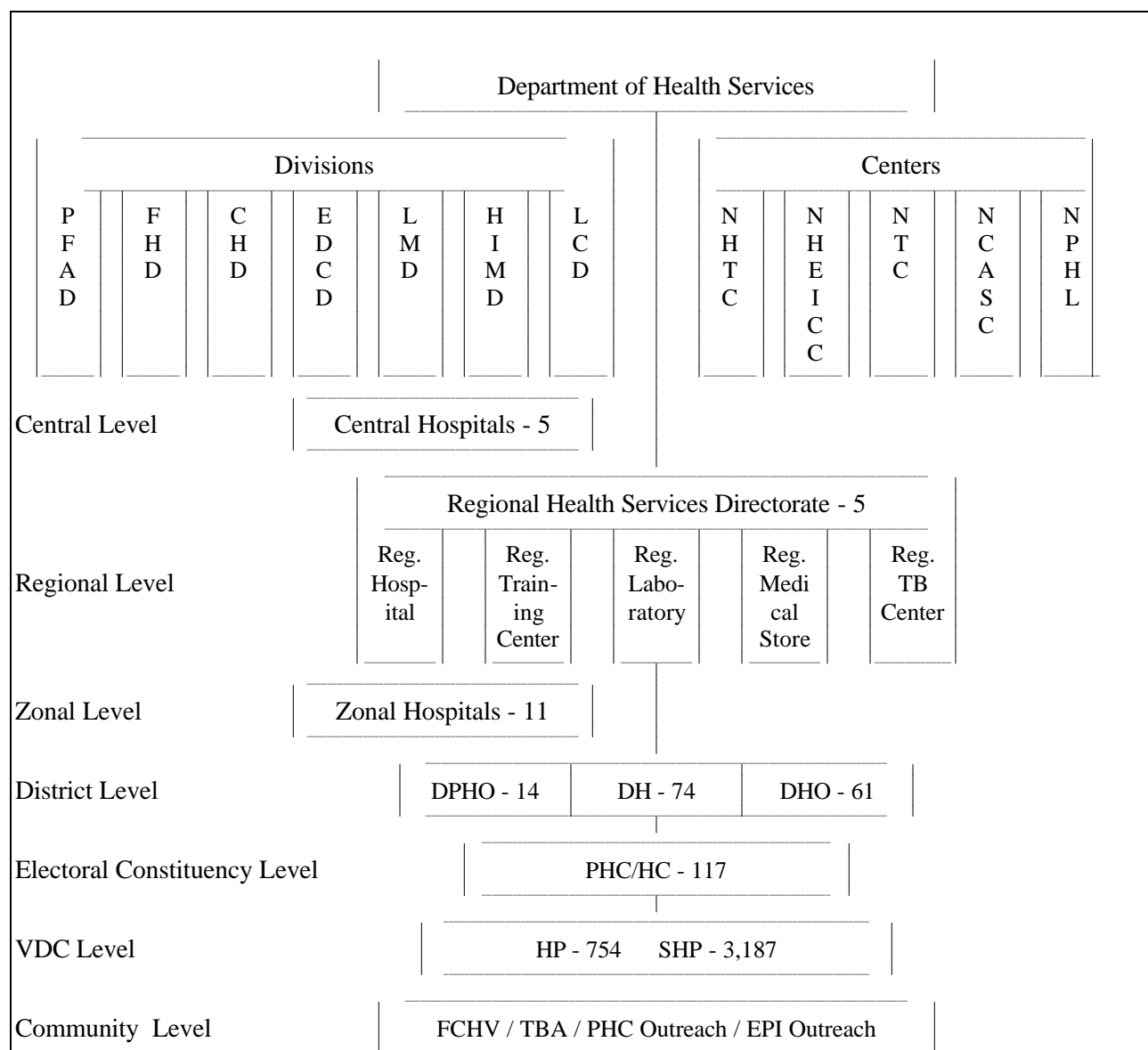
### **Organizations Represented in the Interviews**

Government Organizations	Ministry of Health, Department of Health, Family Health Division; Primary Health Care Center, Kakani; National Center for AIDS and STD Control; Ministry of Population and Environment
Nongovernmental Organizations	New ERA; Family Planning Association of Nepal (local International Planned Parenthood Federation affiliate)
Technical Assistance Organizations	Family Health International; The Centre for Population Development Activities (CEDPA)
Donors	USAID; UNFPA; World Bank
Private Sector	Contraceptive Retail Services (social marketing company)
Service Providers	National Fertility Care Center
Other	Independent consultant working in reproductive health



## Appendix 2

### Organizational Structure of the Department of Health Services



**Source:** Annual Report DoHS, 1996/97.

PFAD Planning and Foreign Aid Division  
 FHD Family Health Division  
 CHD Child Health Division  
 EDCD Epidemiology and Disease Control Division  
 LMD Logistics Management Division  
 HMID Human Manpower Institutional Development  
 LCD Leprosy Control Division  
 NHTC National Health Training Center  
 NHEICC National Health Education, Information, and Communication Center

NTC National Tuberculosis Center  
 NCASC National Center for AIDS and STD Control  
 NPHL National Public Health Laboratory  
 FCHV Female Community Health Volunteer  
 TBA Traditional Birth Attendants  
 PHC Primary Health Care  
 EPI Expanded Programme on Immunization

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